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FOR STATE
HEALTH DEPT.

11418
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11418
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11404

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Mi. W. Red House Mins.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>2001 North Uhl St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edgelon</u> Middle <u>Arnold</u> Last <u>Arnold</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1941</u> 9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Kempton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgel Ford WILSON</u>		14. MOTHER'S MAIDEN NAME <u>Marie Hilton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Marie Wilson, Kempton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fractured Mandible</u> (c) <u>825X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Mins.</u> <u>Mins.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident Rt. 50 Nr. Red House. Husb. operator.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10-22</u> 19 <u>61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Rural Red House Garr. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Oak., Md. 10-22-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/25, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>	22d. LOCATION (City, town, or country) (State) <u>Thomas, W.Va.</u>
23. FUNERAL DIRECTOR <u>J. H. Duncan</u> ADDRESS <u>Thomas, W.Va.</u>		24a. REC'D BY REGISTRAR <u>OCT 25 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11419
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11405

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gorman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marcellus Middle S. Last Arnold				4. DATE OF DEATH Month Oct. Day 28, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1877	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months 8 Days 5 Hours 15 Min.	IF UNDER 24 HRS. Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Washington Arnold				14. MOTHER'S MAIDEN NAME Catherine Wolfe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 236-44-7054		17. INFORMANT Address Mrs. Katie Henline Gorman, W.Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial hypertrophy & failure DUE TO (c) Arterio-sclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MARCH 28, 1949 to OCTOBER 28, 1961 , that (I) (we) last saw the deceased alive on 10/15/1961 and that death occurred at 8:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance				22b. DATE SIGNED 29 Oct 61		22c. PHYSICIAN'S NAME (Type) A. E. MANCE, M.D.	
22d. ADDRESS 101 THIRD ST., OAKLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Oct. 31, 61		23c. NAME OF CEMETERY OR CREMATORY Eglon		23d. LOCATION (City, town, or county) (State) Eglon W.Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Biggs				25a. REC'D BY REGISTRAR DATE NOV 3 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11420

CERTIFICATE OF DEATH

11406

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Addie Middle Myrtle Last Ashby		4. DATE OF DEATH Month October Day 10 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		8. DATE OF BIRTH September 3, 1889			
13. FATHER'S NAME Peter Adams		14. MOTHER'S MAIDEN NAME Sarah E. Roy		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. none		11. BIRTHPLACE (County & State, or foreign country) Tucker County, W. Va.			
17. INFORMANT Stanley Ashby, Crellin, Md. (husband)		12. CITIZEN OF WHAT COUNTRY? United States					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Liver 153.8 DUE TO (b) Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> 21b. DATE SIGNED 10/12/61			
21. I certify that (I) (this hospital) attended the deceased from July 19 50 to October 10 1961, that (I) (we) last saw the deceased alive on October 10 1961, and that death occurred at 1:25p from the causes and on the date stated above.							
22a. SIGNATURE E. I. Baumgartner, M. D.		22b. ADDRESS Oakland, Maryland		22c. PHYSICIAN'S NAME (Type)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/13/61		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery			
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minnich		24b. ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR OCT 16 61			
25b. REGISTRAR'S SIGNATURE Arthur S. Klaus							

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Handwritten notes and stamps, including a date stamp "October 10" and a circular stamp with the letter "I".

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11421

CERTIFICATE OF DEATH

Reg. Dist. No. 11407

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Garrett</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kitzmiller</u>	LENGTH OF STAY (in this place) <u>55yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kitzmiller</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		STREET ADDRESS (If rural give location) <u>Main Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>IDA</u> <u>BELLE</u> <u>BARRICK</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT.</u> <u>11,</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 13, 1874</u>
9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Preston Co., W.Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John A. Garner</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Ellen Mosser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-26-1739</u>	
17. INFORMANT & ADDRESS <u>Archie Barrick, Kitzmiller, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Thrombosis</u>			<u>Despondent</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Heart Disease</u>			<u>5 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct 11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 10</u> , 19 <u>61</u> , and that death occurred at <u>12:55 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Ralph Calabrese</u>		ADDRESS (Street, city, town, state) <u>M.D. Kitzmiller, Md.</u>	
DATE SIGNED <u>Oct 12-61</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 14/61</u>	
NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elk Garden, Mineral Co. W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>OCT 16 '61</u>		REGISTRAR'S SIGNATURE <u>William S. Hume</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Amy M. Sharpless</u>		ADDRESS <u>Blaine, W. Va.</u>	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11422

CERTIFICATE OF DEATH

Reg. Dist. No.

11408

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY GARRETT		STATE MARYLAND		COUNTY GARRETT			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KITZMILLER		LENGTH OF STAY (in this place) 50yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN KITZMILLER			
HOSPITAL OR INSTITUTION OR STREET ADDRESS WILLOW STREET				STREET ADDRESS (If rural give location) WILLOW STREET			
3. NAME OF DECEASED (First) (Middle) (Last) LAURA VIRGINIA BELL				4. DATE OF DEATH (Month) (Day) (Year) OCT. 15, 1961			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Dec. 24, 1877	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SIMON PETER COPIEN				14. MOTHER'S MAIDEN NAME SUSAN E. SHARPLESS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Mrs. Roy Robison, Elk Garden, W. Va.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
493X IMMEDIATE CAUSE (A) Acute Myocardial Infarction						4 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral hemorrhage with rt sided paralysis						1 week	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertension						5 yrs	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 53, to Oct 15, 19 61, that I last saw the deceased alive on Oct 14, 19 61, and that death occurred at 3:45 A.M. from the causes and on the date stated above.							
SIGNATURE <i>Ralph Calandrelli</i>				ADDRESS (Street, city, town, state) Kitzmilller, Md.		DATE SIGNED Oct 16-61	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 17/61		NAME OF CEMETERY OR CREMATORY Philos Cemetery		LOCATION (City, town, or county) (State) Westernport, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Amy M. Sharpless</i>		ADDRESS Blaine, W. Va.	
DATE OCT 17 '61							

CERTIFICATE OF DEATH

1922

File No. 1234

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of registrar (Print or write full name)

12. Signature of undertaker (Print or write full name)

13. Signature of funeral home (Print or write full name)

14. Signature of cemetery (Print or write full name)

15. Signature of church (Print or write full name)

16. Signature of school (Print or write full name)

17. Signature of hospital (Print or write full name)

18. Signature of nursing home (Print or write full name)

19. Signature of other institution (Print or write full name)

20. Signature of other institution (Print or write full name)

21. Signature of other institution (Print or write full name)

22. Signature of other institution (Print or write full name)

23. Signature of other institution (Print or write full name)

24. Signature of other institution (Print or write full name)

25. Signature of other institution (Print or write full name)

26. Signature of other institution (Print or write full name)

27. Signature of other institution (Print or write full name)

28. Signature of other institution (Print or write full name)

29. Signature of other institution (Print or write full name)

30. Signature of other institution (Print or write full name)

31. Signature of other institution (Print or write full name)

32. Signature of other institution (Print or write full name)

33. Signature of other institution (Print or write full name)

MARYLAND

DEPARTMENT OF HEALTH

BALTIMORE, MD

1922

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ENCLOSURE

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11423

11409

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Accident		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Martha Last Bittinger				4. DATE OF DEATH Month October Day 10 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1892		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Jennings, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Gilpen				14. MOTHER'S MAIDEN NAME Mary Jane Fletcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Olive V. Glatfelter, Accident, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma of pancreas DUE TO (b) arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 yr 5 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 , to October 10, 1961 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8:28a , from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance, M. D.				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/10/61	
22c. PHYSICIAN'S NAME (Type) A. E. Mance, M. D.				22d. ADDRESS Oakland, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/14/61		23c. NAME OF CEMETERY OR CREMATORY Rhodes Cemetery		23d. LOCATION (City, town, or county) (State) Garrett Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerold H. Minnich				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR DATE OCT 16 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Fries			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11410

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RD 2, Frostburg			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RD 2, Frostburg		
c. LENGTH OF STAY in 1b Lifetime			d. STREET ADDRESS RD 2, Frostburg		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Helen Middle M. Last Caton			4. DATE OF DEATH Month October Day 12th Year 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12th, 1924		9. AGE (In years last birthday) 37 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Clark			14. MOTHER'S MAIDEN NAME Anna P. Burdock		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 214-34-1549		16. SOCIAL SECURITY NO. 214-34-1549		17. INFORMANT Marshall Caton, RD 2, Frostburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Leukemia Acute Myeloid 20413 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 30 Jan , 1961, to 11 Oct , 1961, that (I) (we) last saw the deceased alive on 11 Oct , 1961, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE F. B. Whitworth M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) F. B. Whitworth,		22d. ADDRESS 123 Bedford St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-14-61	23c. NAME OF CEMETERY OR CREMATORY Fintel Cemetery		23d. LOCATION (City, town or county) (State) RD 2, Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Duvost		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR OCT 16 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11427

11413

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) Rural Swanton				c. LENGTH OF STAY IN 1b 80 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION one mile West of Swanton				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Milfred Middle Charles Last Glass				4. DATE OF DEATH Month October Day 29 , Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1877		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Glass				14. MOTHER'S MAIDEN NAME Caroline Sweitzer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Helen Winters		Address Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Thrombophlebitis of left leg DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 3 days 10 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1950 to Oct 29, 1961 , that (I) (we) last saw the deceased alive on Oct 28, 1961 , and that death occurred at 1:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ralph Calandrella				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Nov 1 - 61	
22c. PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.				22d. ADDRESS Kitzmilller, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/1961		23c. NAME OF CEMETERY OR CREMATORY George Cemetery		23d. LOCATION (City, town, or county) (State) near Swanton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE A. G. Leighton				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE NOV 6 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

B.P.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11428									
11414									
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. STATE WEST VIRGINIA b. COUNTY MINERAL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN 1b 18 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ELK GARDEN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL					d. STREET ADDRESS R. D. # 1 BOX 222			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT PIERCE KITZMILLER					4. DATE OF DEATH Month Day Year OCTOBER 20 19 61				
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 16, 1897		9. AGE (In years last birthday) 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER			10b. KIND OF BUSINESS OR INDUSTRY SOFT COAL			11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME ULYSSES G. KITZMILLER					14. MOTHER'S MAIDEN NAME SCHWINABART SHAWINABART, VICTORIA				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 220-10-0435		17. INFORMANT Address MRS. DESSIE BURTON CLARKSBURG, W. VA.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Agelo-lymphocytic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (b) Leukemia DUE TO (c) Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10/2/61 19....., to 10/20/61 , 19....., that (I) (we) last saw the deceased alive on 10/20/61 19....., and that death occurred at 1:15 A.M. the causes and on the date stated above. 22a. SIGNATURE A. E. Mance 22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE 22b. DATE SIGNED 2/10/61 22d. ADDRESS OAKLAND, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/22/1961		23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery		23d. LOCATION (City, town or county) (State) Elk Garden, W. Va.		
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless					25a. REC'D BY REGISTRAR ADDRESS Oakland, Md. Blaine, W. Va. DATE OCT 26 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
11415

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b minutes			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS Pennington Street							
3. NAME OF DECEASED (Type or print) First Bess Middle Littman Last Lawton				4. DATE OF DEATH Month October Day 3 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 24, 1883	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10		11. IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Swanton, Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Louis Littman				14. MOTHER'S MAIDEN NAME Cecelia Taggart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Arthur Lawton, Jr. (son) Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Arteriosclerosis (b) 5 yrs (c) 10 yrs INTERVAL BETWEEN ONSET AND DEATH 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from February 14, 1946 to October 3, 1961 , that (I) (we) lost saw the deceased alive on October 3, 1961 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE A. E. Mance, M.D.				22b. DATE October 3, 1961		22c. ADDRESS Oakland, Maryland	
22c. PHYSICIAN'S NAME (Type) A. E. Mance, M. D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
23d. LOCATION (City, town, or county) (State) Oakland Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Gerald D. Minnich				25a. REC'D BY REGISTRAR DATE OCT 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	
ADDRESS Oakland, Maryland							

October 3 61
Reprinted at 40 October 3 61

October 3 61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14 Film G297 10/20/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 11416

11430

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland Allegany b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 49 Marion St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Pearl		4. DATE OF DEATH First Leslie Last October 11 19 61		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1887		9. AGE (In years last birthday) 74 yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) White Sulphur Springs, Va., U.S.A.													
13. FATHER'S NAME unknown Reynolds				14. MOTHER'S MAIDEN NAME unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)													
16. SOCIAL SECURITY NO.				17. INFORMANT Goldie Nazelrod, Cumberland, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis DUE TO Arteriosclerosis (c) Arteriosclerosis													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastritis, Peri-Renal Abscess				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 2 weeks													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town)				(County)				(State)													
21. I certify that I attended the deceased from 10-10 , 19 60 , to 10-11 , 19 61 , that I last saw the deceased alive on 10-11 , 19 61 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.																					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>						ADDRESS (Street, city or town, state) M.D. 58 2nd St. OAKLAND MD															
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M.D.						DATE SIGNED 10-11-61															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct. 14, 1961				22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park													
22d. LOCATION (City, town, or county) Cumberland, Maryland				(State)																	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein</i>						ADDRESS 117 Frederick St. Cumb. Md.															
24a. REC'D BY REGISTRAR						24b. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>															
DATE OCT 16 '61																					

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2646

11431

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Friendsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Friendsville MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>Michael</u> Last <u>s</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12 1884</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Harvey Michaels</u> Address <u>Friendsville, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>CARDIOVASCULAR FAILURE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>61</u> , to <u>Sept</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept</u> , 19 <u>61</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Pedro Rivera</u> M.D.				ADDRESS (Street, city or town, state) <u>Friendsville, Md</u> DATE SIGNED <u>10-10-61</u>			
PHYSICIAN'S NAME (Type) <u>PEDRO RIVERA MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Oct 11, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sand Spring Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Friendsville, Garrett MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Pious</u>	

CERTIFICATE OF DEATH

1131

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1890</u></p>	
<p>4. Place of birth: <u>MASSACHUSETTS</u></p>	
<p>5. Date of death: <u>1945</u></p>	
<p>6. Place of death: <u>MASSACHUSETTS</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>	
<p>8. Duration of illness: <u>10 days</u></p>	
<p>9. Name of physician: <u>Dr. J. J. Smith</u></p>	
<p>10. Name of funeral home: <u>None</u></p>	
<p>11. Name of next of kin: <u>None</u></p>	
<p>12. Name of informant: <u>None</u></p>	
<p>13. Name of registrar: <u>None</u></p>	
<p>14. Name of registrar: <u>None</u></p>	
<p>15. Name of registrar: <u>None</u></p>	
<p>16. Name of registrar: <u>None</u></p>	
<p>17. Name of registrar: <u>None</u></p>	
<p>18. Name of registrar: <u>None</u></p>	
<p>19. Name of registrar: <u>None</u></p>	
<p>20. Name of registrar: <u>None</u></p>	
<p>21. Name of registrar: <u>None</u></p>	
<p>22. Name of registrar: <u>None</u></p>	
<p>23. Name of registrar: <u>None</u></p>	
<p>24. Name of registrar: <u>None</u></p>	
<p>25. Name of registrar: <u>None</u></p>	
<p>26. Name of registrar: <u>None</u></p>	
<p>27. Name of registrar: <u>None</u></p>	
<p>28. Name of registrar: <u>None</u></p>	
<p>29. Name of registrar: <u>None</u></p>	
<p>30. Name of registrar: <u>None</u></p>	
<p>31. Name of registrar: <u>None</u></p>	
<p>32. Name of registrar: <u>None</u></p>	
<p>33. Name of registrar: <u>None</u></p>	
<p>34. Name of registrar: <u>None</u></p>	
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<p>36. Name of registrar: <u>None</u></p>	
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<p>38. Name of registrar: <u>None</u></p>	
<p>39. Name of registrar: <u>None</u></p>	
<p>40. Name of registrar: <u>None</u></p>	
<p>41. Name of registrar: <u>None</u></p>	
<p>42. Name of registrar: <u>None</u></p>	
<p>43. Name of registrar: <u>None</u></p>	
<p>44. Name of registrar: <u>None</u></p>	
<p>45. Name of registrar: <u>None</u></p>	
<p>46. Name of registrar: <u>None</u></p>	
<p>47. Name of registrar: <u>None</u></p>	
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<p>78. Name of registrar: <u>None</u></p>	
<p>79. Name of registrar: <u>None</u></p>	
<p>80. Name of registrar: <u>None</u></p>	
<p>81. Name of registrar: <u>None</u></p>	
<p>82. Name of registrar: <u>None</u></p>	
<p>83. Name of registrar: <u>None</u></p>	
<p>84. Name of registrar: <u>None</u></p>	
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<p>86. Name of registrar: <u>None</u></p>	
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<p>88. Name of registrar: <u>None</u></p>	
<p>89. Name of registrar: <u>None</u></p>	
<p>90. Name of registrar: <u>None</u></p>	
<p>91. Name of registrar: <u>None</u></p>	
<p>92. Name of registrar: <u>None</u></p>	
<p>93. Name of registrar: <u>None</u></p>	
<p>94. Name of registrar: <u>None</u></p>	
<p>95. Name of registrar: <u>None</u></p>	
<p>96. Name of registrar: <u>None</u></p>	
<p>97. Name of registrar: <u>None</u></p>	
<p>98. Name of registrar: <u>None</u></p>	
<p>99. Name of registrar: <u>None</u></p>	
<p>100. Name of registrar: <u>None</u></p>	

1
FOR STATE
HEALTH DEPT.
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																								
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
11432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																								
11417																								
1. PLACE OF DEATH a. COUNTY Garrett					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					b. COUNTY Garrett														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville					c. LENGTH OF STAY in lb Life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Lawrence Conrad Miller					4. DATE OF DEATH Month Oct. 18th. 1961					Day Year														
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1908 Oct. 7 1908		9. AGE (In years last birthday) 53 1/2 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner Mines					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Grantsville, Md.					12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Wilson E. Miller					14. MOTHER'S MAIDEN NAME Lydia Wissman					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W. W. II					16. SOCIAL SECURITY NO.					17. INFORMANT Ivan Miller, Grantsville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage, massive, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Tuberculosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Sudden Undetermined														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> James H. Feaster, Jr., M. D. Oak., Md. 10-18-61																								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 10-21-61					22c. NAME OF CEMETERY OR CREMATORY Grantsville, Md.					22d. LOCATION (City, town, or country) (State) Grantsville, Garr. Md.									
23. FUNERAL DIRECTOR ADDRESS Grantsville, Md.					24a. REC'D BY REGISTRAR DATE OCT 23 '61					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus														

FOR THE
RECORD
1941

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1941

CHURCH OF DEATH

11433

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CERTIFICATE OF DEATH

Reg. Dist. No.

11419

11434

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville, Md.				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Goodwill Mennonite Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE W. TIPTON				4. DATE OF DEATH October 10 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR 77 Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soft drink bottler & distributor		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co., Pa.	
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Tipton				14. MOTHER'S MAIDEN NAME Emma Reitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 180-28-0041			
17. INFORMANT Leland Tipton, 603 Div. St., Berlin, Pa.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic heart disease (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct. 3, 1961 to Oct. 10, 1961 that I last saw the deceased alive on Oct. 9, 1961 , and that death occurred at 1:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Paige Strong M.D.				DATE SIGNED Oct. 10, 1961			
PHYSICIAN'S NAME (Type) A. Paige Strong				ADDRESS (Street, city or town, state) Grantsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10-13-61		22c. NAME OF CEMETERY OR CREMATORY IOOF	
22d. LOCATION (City, town, or county) (State) Berlin, Somerset Co., Pa.				22e. REC'D BY REGISTRAR Arthur L. Hanna			
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Maryland				24. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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VS. A15ME
5M 9/60

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman		c. LENGTH OF STAY IN lb Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Mi. West in Woods along Rt. #50		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Russell Walters		4. DATE OF DEATH October 7, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 14, 1889	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Walters		14. MOTHER'S MAIDEN NAME Lula West	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 236-14-6857	
17. INFORMANT Mrs. Bertha Harvey		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420-1 Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Mins	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE James H. Feaster Jr.		DATE SIGNED 10-7-61	
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.		Address (Street, city, town, or county) Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/1961	
22c. NAME OF CEMETERY OR CREMATORY Pope Cemetery		22d. LOCATION (City, town, or country) (State) Gorman, Garrett Co., Md.	
23. FUNERAL DIRECTOR H. C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 10-13-61		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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